Outreach Physical & Occupational Therapy
& Speech Rehabilitation, PLLC
CLINIC SETTING
Please fax below OR your standard Rx **to (917-591-8494)**
Thank You for Your Referral

Patient Information:
Full Name (as on Insurance ID card)____
Address_______________________________ City___________State____Zip___________
Home Phone #__________________________ Cell #__________________ email:__________
Social Security #_________________________ Date of Birth__________________________
Family/Friend/Emergency Contact Name____
Relationship_____________________Ph #_________________ email____________________

Rx: by Referring MD/DO/DPM/NP (or attach your standard Rx)**:**

Referrer Name:_________________________NPI#_____________________
Address: _____________________Ph.# /Fax #____________________/________________
Email:___________________________
I certify these services as medically necessary for the patient's plan of care

Referring Provider Signature:___________________________Date:_____________________

Rx Therapy:☐ Physical ☐ Occupational ☐Speech (Medicare only)
Frequency/Duration:______________ x/week for _______________weeks
Diagnosis:___________________________

Medical History and Precautions: ____

Patient Insurance Information:

In Network Physical/Occupational: ☐ Medicare ☐ Cigna ☐ Aetna ☐ U.S. Family
☐ United Health Care ☐ Workers Compensation
☐ No fault ☐ GEHA ☐ BCBS☐ GHI/emblem
☐Humana Medicare

Out of Network: ☐ Humana

Private Pay: ☐PT ☐ OT ☐ SLP: ($110/Session (up to 60 minutes) $60/session (up to 30 minutes)

Above Primary Ins. Member ID #_______________________

Secondary Ins.: Company Name / Member ID #______________________/______________________

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